INFORMED CONSENT (amended October 2019)

NAME: _____

date: _____ (block letters please)

PREAMBLE: The information contained separately on EXPANDED INFORMED CONSENT (Pages 1-10) requires the same CONSENT registered here. These 10 pages are meant to inform you, and your doctor, if desired, if chosen by you, even more fully about what to expect from AcuDestress. As such, it the description is intentionally lengthy, AcuDestress differs in form and intent from most other methods of stress management - resembling a number of other treatments, like rTMS, which use other forms of neuromodulation as we use 5-point ear acupuncture. This is not "talk therapy" as we know it, but training-based transpersonal psychotherapy.

This longer form was constructed to help your family doctor or social worker know about your treatment in detail. It suggests approaches for care-givers afterwords. This document is additionally posted on our web site. More doctor-oriented information is at: http://www.acudestress.ca/clinician/ Doctor-to-Doctor.html

CONSENT

1.) I agree to hold in strict confidence anything said by a member of the group and any material I access from the day-to-day passworded web site. I accept that I may share stories, but no material which has anyone's name attached to it....

_____ (initials)

2.) I agree to receive Smith's 5-point ear acupuncture at sessions when offered, as provided by Dr. Bailey or a trained (Ontario Bill 50) member of his staff. I agree further to keep track of all of my acupuncture needles such that I do not leave the room until all 10 of my needles are returned.

_____ (initials)

3.) I agree to demographic parts of my records (name, address, OHIP and date of birth etc) being stored on an AcuDestress-designated website, which is password protected. I agree that information about me, may be communicated by unencrypted e-mail to me and to others in my "circle of care", at the discretion of Dr. Bailey.

_____(initials

4.) I agree that the session may be conducted over the *Ontario Telemedicine Network*, or in-person. I have received assurances that such telecasting is is secure. I agree that this treatment may include viewing videos of former group members and such members attending the group, and agree to keep their names and videos confidential.

_____(initials)

5.) I agree to attend the group with as full attendance as possible, and that the success of my treatment can depend on regular attendance.

_____ (initials)

6.) I understand that the nature of transpersonal group therapy, does not plan or lend itself to processing interpersonal issues among members (including persons related to each other). While persons related, 16 years and older ,may attend when permitted to do so, I understand that this therapy is not meant to repair relationships between members. I accept that I will never be asked, expected or encouraged to reveal confidential information, but if I do, it will be by my own choice

_____(initials)

I CONSENT to the treatment offered above subject to any exceptions I have not initialled.

_____

(signature)